BEFORE THE
UNITED STATES OF AMERICA
NATIONAL LABOR RELATIONS BOARD

SPECIALTY HEALTHCARE AND REHABILITATION CENTER OF MOBILE, Employer, and UNITED STEELWORKERS, DISTRICT 9, Petitioner.	Case 15-RC-8773

BRIEF OF AMICUS CURIAE SERVICE EMPLOYEES INTERNATIONAL UNION

Judith A. Scott, General Counsel
John J. Sullivan, Associate General Counsel
Ryan E. Griffin, Law Fellow
Service Employees International Union
1800 Massachusetts Avenue, NW
Washington, DC 20036
(202) 730-7327

Counsel for Service Employees International Union as Amicus Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes and Regulations

Legislative and Administrative Materials

Miscellaneous

INTEREST OF AMICUS CURIAE

SEIU represents over two million members across the United States, Canada, and Puerto Rico working in three primary service industries: healthcare, property services, and public services. As the largest healthcare union in the United States, SEIU represents more than 1.2 million workers in hospitals, nursing homes, clinics, home care agencies, and other health care institutions. Of particular relevance to this case, SEIU represents approximately 160,000 nursing home workers, many of them certified nursing assistants (CNAs), across eighteen states.

INTRODUCTION

The issue before the Board is whether a bargaining unit consisting solely of nursing home CNAs working in an unorganized nursing home[1] is appropriate under the National Labor Relations Act. In its Notice and Invitation to File Briefs, the Board has asked interested parties to address a number of broad questions including the relevance of the hospital bargaining unit rules and the relationship between the *Park Manor* "pragmatic or empirical" standard and the traditional community of interest standard articulated by the Board in *American Cyanamid Co.*, 131 NLRB 909, 910 (1961), in determining appropriate units in nursing homes. *See Specialty Healthcare and Rehabilitation Center of Mobile*, 356 NLRB No. 56, slip op. at 1–2 (2010).

The resolution of this case does not depend upon the adoption of any one of these standards for determining appropriate units. The CNA unit at issue in this case is appropriate under any of the unit determination standards identified by the Board, with the exception of an

[1] The discussion of the standards for determining appropriate bargaining units analyzed in this brief is limited to situations involving unorganized workers without a relevant history of collective bargaining. In cases involving the severance of a group of employees from an existing bargaining unit a different standard applies. In such "severance" cases a unit of severed employees must possess "special and distinct interest as would outweight [sic] and override the community of interests shared" with the existing unit. *Kalamazoo Paper Box Corp.*, 136 NLRB 134, 137 (1962). *See also Wheeling Island Gaming, Inc.*, 355 NLRB No. 127, slip. op. at 3 (2010) (Member Becker dissenting) ("[A] heightened showing of distinctiveness might be appropriate to justify severing a group of employees from an existing unit.").

inflexible application of the acute care hospital bargaining unit rules, which on their face exclude nursing homes, *see* Rules and Regulations of the NLRB § 103.30(g). The goal of amicus SEIU is to educate the Board on the occupational and operational dynamics of the nursing home industry as they relate to CNAs. To this end, our brief addresses the unique role of CNAs relative to other nonprofessional nursing home employees. We also address nursing home CNAs' functional similarity to the primary caregivers in acute care hospitals, the registered nurses (RNs). As we demonstrate below, nursing home CNAs share a community of interest that is not only sufficiently distinct to be unmistakably appropriate under the traditional community-of-interest standard, but also sufficiently compelling to overcome the Board's concern—articulated in the hospital rules and reflected in *Park Manor*—with avoiding unnecessary unit proliferation.

ARGUMENT

I. NURSING HOME CNAs PLAY A UNIQUE AND VITAL ROLE IN THE HEALTHCARE INDUSTRY.

Nursing homes, which provide nonacute long term care to millions of older and disabled Americans, present a starkly different environment than acute care hospitals. All nursing homes provide a similar, limited range of services, primarily assistance with activities of daily living such as eating, dressing, and bathing. In addition to these residential services, nursing homes provide a limited range of basic medical services including monitoring residents' health indicators, such as blood pressure and respiration, and administering intravenous and other medications.

The direct care staff at almost all nursing homes is comprised of RNs, licensed practical nurses (LPNs), and CNAs. *See Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* 143 (Gooloo S. Wunderlich et al. eds., 1996) [hereinafter *Nursing Staff*]. All three classifications

work under the director of nursing, an RN. *See id.* at 141. Mid-level supervisors may be either RNs or LPNs depending on the size of the facility and the level of care provided. Nursing homes generally do not have physicians on staff and have few, if any, technical employees other than LPNs. *See* Second Notice of Proposed Rulemaking, 53 Fed. Reg. 33,900, 33,928 (Sept. 1, 1988).

In addition to direct care workers, nursing homes and hospitals employ a variety of employees classified as "nonprofessional" under the hospital unit rules including dietary, housekeeping, clerical, and maintenance employees. *See* Rules and Regulations of the NLRB § 103.30(a)(8). At issue in this case is whether a unit of CNAs working in an unorganized nursing home that does not include these nonprofessional employees is appropriate. The employer argues that such a unit is inappropriate because the acute care hospital rules would not permit a unit of nurse assistants (NAs)[2] separate from other nonprofessional employees. The employer's argument ignores: (1) the unique evolution of the hospital bargaining unit rules; (2) the explicit exclusion of nursing homes from the health care institutions covered by those rules; (3) the many critical differences between nursing homes and acute care hospitals, including the wide variety of healthcare function performed in acute care hospitals by an equally wide array of professional and nonprofessional employees; (4) the licensing and certification requirements that define the role of CNAs in nursing homes but do not regulate nonprofessional hospital employees; and (5) CNAs' relationship with other nonprofessional nursing home staff. The following subsections explain these important distinctions.

A. The Work of a CNA Differs Markedly from that of Other Nursing Home Employees.

[2] Nurse assistants, nurse aides, and orderlies in hospitals (collectively referred to in this brief as NAs) provide nonmedical assistance to patients and assist licensed nurses with medical care. However, unlike nursing home CNAs, hospital NAs are not subject to state certification requirements. *See infra* Part I.B.

CNAs serve as the primary caregivers in the nursing home setting. *See* Bureau of Labor Statistics (BLS), *Nursing and Psychiatric Aides, in Occupational Outlook Handbook* (2010–11 ed.) [hereinafter BLS *Handbook*].[3] According to some estimates, CNAs comprise upward of seventy percent of the nursing staff in nursing homes and provide up to ninety percent of direct patient care. *See Nursing Staff*, *supra*, at 156. As a group, CNAs staff a nursing home twenty-four hours a day, seven days a week.

CNAs perform nearly all of the routine care tasks in nursing homes including feeding, bathing, dressing, grooming, and transferring or transporting residents, as well as changing linens and tidying resident living areas. *See* BLS *Handbook*, *supra*. In addition, they monitor residents' physical, mental, and emotional conditions for medical staff. *Id.* CNAs often are responsible for taking temperature, pulse rate, respiration rate, and blood pressure readings and assisting medical staff with equipment, supplies, and some procedures. *Id.*

Congress recognized the essential nature of nursing home CNA services as early as 1987, when it sought to improve the quality of nursing home care funded under Medicare and Medicaid by promulgating standards for nursing home staffing and caregiver training. *See* 42 U.S.C. § 1396r (2006). These federal regulations require nursing home CNAs to be certified by the state and to undergo at least seventy-five hours of training within four months of being hired. *See* 42 C.F.R. § 483.75(e) (2010). This training course must cover a core list of subjects and include at least sixteen hours of supervised practical training. *See id.* § 483.152. Federal law requires every state to maintain a registry of all CNAs who have completed the state certification requirements. 42 U.S.C. § 1396r(e)(2)(A). These registries must also make available to the public any findings by the state of resident neglect or abuse by a CNA. *Id.* at (e)(2)(B).

[3] *Available at*: http://www.bls.gov/oco/ocos327.htm.

Approximately half the states impose additional training requirements above those required by federal law, including annual continuing education requirements. *See* Esther Hernández-Medina, *Training Programs for Certified Nursing Assistants*, AARP Public Policy Institute # 2006-08, Mar. 2006.[4] Most states also require CNAs to complete a criminal background check prior to being placed on these registries. *See* BLS *Handbook*, *supra*.

CNAs work closely with other nursing personnel (RNs and LPNs) in providing these direct care services to residents. Like the other nursing staff in nursing homes, CNAs work under the supervision of the director of nursing and other licensed supervisory nursing personnel. *See* Charlene Harrington et al., *Experts Recommend Minimum Nursing Staffing Standards for Nursing Facilities in the United States*, 40 The Gerontologist 5, 6 (2000) (discussing federal requirements for RN and/or LPN supervision).

In contrast to CNAs, the nonprofessional staff in dietary, housekeeping, and maintenance departments interact with residents only indirectly, if at all. These employees work under the direction of administrators responsible for non-direct care operations instead of under nursing supervisors. As a result, CNAs have relatively little interaction with their nonprofessional colleagues. Interchange between these nonprofessional employees and CNAs is also strictly limited due to the regulatory regime, which prohibits non-nursing employees from performing most CNA tasks.

CNAs' integral role in providing direct patient care results in occupational difficulties not shared by their nonprofessional colleagues. For example, CNAs suffer some of the highest incidence of non-fatal workplace injuries for all occupations. *See* BLS *Handbook*, *supra* (noting that CNAs and NAs ranked in the 98th percentile for injury rates among all occupations in 2007). CNAs and NAs as a group rank only slightly behind police officers and emergency

[4] *Available at*: http://assets.aarp.org/rgcenter/il/inb122_cna.pdf.

medical personnel and slightly ahead of correctional officers and fire fighters in incidence of nonfatal injury. *See* Bureau of Labor Statistics, *2009 Nonfatal Occupational Injuries and Illnesses: Private Industry, State Government, and Local Government* at Chart 5 (Nov. 9, 2010).[5]

Back injuries resulting from lifting and transferring residents into and out of beds, wheelchairs, and showers are particularly problematic for nursing home CNAs. *See* BLS *Handbook*, *supra.* One leading cause of back injuries during these activities is attempting one-person lifts due to inadequate staffing. *See Nursing Staff*, *supra,* at 174. Another significant cause of injury is a lack of proper training on lifting techniques and the use of assistive devices. *See id.* (noting that assistive devices are rarely used due to a lack of accessibility and skill, among other factors). These difficulties are particularly acute among new staff and can have a spiraling effect as "[u]nderstaffing (both qualitative and quantitative) leads to injuries, which leads to further understaffing." *Id.*

In addition to the physically demanding nature of their job, nursing home CNAs work in an environment that is often mentally and emotionally stressful due to the immediate and constant proximity with aging, disabled, and dying residents and a variety of unpleasant tasks such as dealing with urinary and bowel incontinence. *See id.* at 370.

In light of these conditions, it is unsurprising that nursing homes have a national turnover rate among CNAs of over 70% annually and rates in some states that exceed 100%. *See* Eric Collier & Charlene Harrington, *Staffing Characteristics, Turnover Rates, and Quality of Resident Care in Nursing Facilities*, 1 Research in Gerontological Nursing, 157, 161 (2008); Charlene Harrington et al., *supra,* at 7; *Nursing Staff*, *supra,* at 430–33. Studies have found that these high turnover rates are associated with low staffing levels. *See* Collier & Harrington, *supra,* at 161–62.

[5] *Available at*: http://www.bls.gov/iif/oshwc/osh/case/osch0043.pdf.

These labor instability and workforce shortage problems among CNAs have a far greater impact on the quality of resident care than any similar problems involving non-direct care employees due to CNAs' central role in providing direct resident care. Studies have concluded that CNA turnover rates greater than 50% are associated with poorer quality of care. *See id.* at 161–62. Understaffing among CNAs can result in care that is hurried and less than adequate. *See* Harrington et al., *supra*, at 7 (citing studies reporting that CNAs "cut corners to manage workloads and lack time to provide high quality, individualized care given the requirements for institutional efficiency and the high work volume").

Workforce shortages may also contribute to the extremely high rate of wage and hour law violations by nursing homes. CNAs are often required to work uncompensated hours beyond the ends of their shifts in order to complete the required tasks and associated reporting for each resident under their care. *See* Wage and Hour Div., U.S. Dep't of Labor, *Nursing Home 2000 Compliance Survey Fact Sheet* (2000).[6] In an industry in which wage and hour violations are not uncommon, CNAs are the most frequent victim of such violations among nursing home occupations. *Id.*

The above difficulties for nursing home CNAs are exacerbated by their narrow job market and limited career ladder. Unlike their nonprofessional colleagues in dietary, housekeeping and maintenance—who can work in a wide variety of industries—CNAs are limited to the healthcare field. This field is further limited by the fact that although CNAs sometimes work for home health or community care services, the wages in these industries are lower than in nursing homes. *See* BLS *Handbook*, *supra*. Finally, CNAs' career ladder in nursing homes is also extremely limited due to the federal regulatory regime that assigns CNAs a limited number of tasks and reserves more complex procedures for RNs or LPNs.

[6] *Available at*: http://www.dol.gov/whd/healthcare/surveys/nursing2000.htm.

B. Nursing Home CNAs and Hospital NAs Play Significantly Different Roles in Their Respective Healthcare Facilities.

The extensive body of federal and state regulations governing CNA work in nursing homes, *see supra* Part I.A, reflects heightened recognition by Congress and state legislatures of the crucial role CNAs play in providing direct care in nursing homes. *See, e.g.*, Cal. Health & Safety Code § 1337(a) (2010) ("The Legislature finds that the quality of patient care in skilled nursing and intermediate care facilities is dependent upon the competence of the personnel who staff its facilities. . . . [D]irect patient care in skilled nursing and intermediate care facilities is currently rendered largely by certified nurse assistants.").

Hospital NAs have a far less significant impact on care outcomes than their nursing home counterparts. Unlike nursing homes, the typical acute care hospital is a large and complex institution that provides a vast array of medical services—such as emergency care, intensive care, surgery, recovery, rehabilitation, neonatal care, behavioral health, and outpatient services—across a wide variety of departments. *See, e.g.*, *Oakwood Healthcare, Inc.*, 348 NLRB 686, 686 (2006) (noting that 181 direct care RNs staffed the ten separate patient care units of the 257-bed acute care hospital). These departments are staffed by specialized teams of physicians, surgeons, nurses, technical employees (e.g., laboratory, x-ray, and EKG technicians and physical, behavioral, radiation, and respiratory therapists), and aides. In this environment, care outcomes are to a much larger extent driven by the medical decisions and RN staffing levels instead of the routine care provided by nurse assistants. *See* Jack Needleman et al., *Nurse-Staffing Levels and the Quality of Care in Hospitals*, 346 N. Engl. J. Med. 1715, 1719 (2002) (finding greater numbers of RN-hours but not aide-hours to be associated with shorter hospital stays among medical patients and lower rates of failure to rescue among surgical patients).

Hospital NAs are not subject to the comprehensive regulatory regime governing CNA work in nursing homes. The federal CNA requirements apply only to nursing homes. *See Nursing Staff*, *supra*, at 70. Moreover, many states do not extend their certification or registry requirements to hospital NAs. *See, e.g.*, Mass. Office of Health and Human Services, *Overview of Accessing the Nurse Aide Registry* ("The Department maintains a registry of . . . individuals certified as nurse aides pursuant to federal long term care facility regulations . . . ."); [7] N.J. Dep't of Health and Senior Services, *Certification of Nurse Aides in Long-term Care Facilities and Personal Care Assistants in Assisted Living Facilities* ("The State of New Jersey does not require nurse aides to be certified to work in an acute care hospital."). [8]

II. A CNA-ONLY UNIT SHOULD BE DEEMED APPROPRIATE UNDER ANY RECOGNIZED STANDARD FOR DETERMINING APPROPRIATE BARGAINING UNITS.

A. Nursing Home CNAs Share a Distinct Community of Interest.

In all industries other than healthcare, the Board applies its familiar community-of-interest standard for determining appropriate bargaining units. *See Specialty Healthcare*, 356 NLRB at slip op. 3. In applying this standard, the Board considers "similarity of wages and hours, extent of common supervision, [and] frequency of contact with other employees . . . ." *Park Manor*, 305 NLRB 872, 875 (1991). Additionally, the Board may consider the degree of interchange, the presence or lack of shared skills or cross-training, and general working conditions. *See, e.g.*, *United Rentals, Inc.*, 341 NLRB 540 (2004); *United Operations, Inc.*, 338 NLRB 123 (2002).

When these factors are applied to nursing home CNAs, there is little doubt that they share a community of interest among themselves. As set forth in Part I, *supra*, CNAs possess a

[7] http://www.mass.gov (search for document by title) (last visited Mar. 5, 2011).
[8] Http://www.state.nj.us/health/healthfacilities/nadetail.shtml (last visited Mar. 5, 2011).

standard set of skills and perform a standard range of tasks. CNAs work under the supervision of a director of nursing and primarily interact with the licensed nurses (RNs and LPNs) who also provide direct care under the same supervision. CNAs must meet uniform, federally-mandated training and certification requirements. Interchange with both non-direct care nonprofessionals and licensed nursing staff is severely limited due to the federally-required regulations that prohibit non-nurses from performing most CNA tasks and prohibit CNAs from performing tasks reserved for LPNs or RNs. CNAs face identical scheduling concerns regarding night and weekend work and earn similar wages due to the industry-specific nature of the CNA job market.

Indeed, it would be highly unusual if a group of employees performing the same job in the same facility did not share a community of interest. *See Wheeling Island Gaming, Inc.*, 355 NLRB No. 127, slip. op. at 2 (2010) (Member Becker, dissenting) ("The poker dealers [at a single casino] clearly share a community of interest, as they have virtually identical terms and conditions of employment."). In some situations—for example RN units in hospitals—the Board has found such a community of interest deserving of presumptively appropriate status. Even variations among such employees in terms of wages, benefits, scheduling, and supervision does not destroy a community of interest. *See, e.g.*, *K.G. Knitting Mills, Inc.*, 320 NLRB 374, 374 (1995) (finding variations in health insurance benefits, scheduling, and degree of supervision inadequate reasons for excluding employees from the unit sought); *Banknote Corp. of Am.*, 315 NLRB 1041, 1043 (1994) ("[D]ifferences in compensation rates do not destroy a community of interest among employees"), *enf'd* 84 F.3d 637 (2d Cir. 1996).

For all these reasons, an employer could not reasonably object to the CNA unit under the community-of-interest standard on the ground that CNAs do not share a community of interest. Instead, the only basis for objection would be that the unit must include additional employees

from other job classifications. This is precisely the objection the employer in this case has raised relying upon *Park Manor*.

This objection has little force under the traditional community-of-interest analysis. It is fundamental under the National Labor Relations Act (NLRA) that the Board need only find *an* appropriate unit, not the *most* appropriate unit. *See Morand Bros. Beverage Co.*, 91 NLRB 409, 418 (1950). In *American Cyanamid*, for example, the Board first introduced the community-of-interest approach by approving a maintenance unit separate from production employees on the grounds that maintenance employees were "readily identifiable as a group whose similarity of function and skills create a community in interest such as would warrant separate representation." 131 NLRB at 910. In rejecting the employer's challenge to the maintenance unit, the Board stated that the employer had failed to establish that its operation was "so integrated . . . that maintenance employees are not separately identifiable." *Id.*

Since *American Cyanamid*, the Board has consistently placed on objecting employers the substantial burden of showing that the unit sought is inappropriate, not merely that a broader unit might also be appropriate or even more appropriate. *See, e.g., Seaboard Marine, Ltd.*, 327 NLRB 556, 556 (1999) (agreeing that unit sought was inappropriate only after finding that the unit was "arbitrary" due to the "high degree of functional integration" in the employer's operation). Although the Board has relied on different formulations of the employer's burden, it is clear that this burden is not lightly met. As the D.C. Circuit explained in *Blue Man Vegas, LLC v. NLRB*, 529 F.3d 417, 421 (D.C. Cir. 2008), a unit of employees who share a community of interest can be rejected only if it is "truly inappropriate" in that "there is no legitimate basis upon which to exclude certain employees."

CNAs are sufficiently distinct from other nursing home nonprofessionals to be easily deemed an appropriate independent unit under the community-of-interest standard. As discussed in Part I, *supra*, in contrast to the dietary, housekeeping, and maintenance employees that the employer argues must be included in the CNA unit, CNAs:

- Are engaged in direct care unlike the dietary, housekeeping, and maintenance employees, who interact with residents indirectly if at all;
- Are supervised by the director of nursing and other supervisory RNs and LPNs, while other nonprofessional employees generally work under the direction of non-nursing administrators;
- Are as a group generally responsible for 24/7 coverage, while most dietary, housekeeping, and maintenance work is limited to day or evening hours;
- Are the primary direct care providers in nursing homes, a role that gives rise to distinct safety concerns due to activities such as unassisted lifting;
- Face distinct staffing concerns due to high staff turnover and workforce shortages that generate pressure from management to work extended, often uncompensated, hours;
- Are governed by state and federal regulations including certification requirements, including significant and ongoing education and training requirements, which do not apply to other nursing home nonprofessionals;
- Earn higher average wages than other nonprofessional nursing home workers, reflecting the greater educational, scheduling, and safety demands placed on CNAs.

- Have little interchange with other nursing home employees due to federal and state regulations that prohibit non-nurses from performing CNA functions and bar CNAs from performing certain functions reserved to RNs or LPNs.

Taken together, these facts leave no room for doubt that a CNA unit is appropriate under the generally applicable community of interest standard used in every industry other than healthcare.

Alternatively, if the Board concludes that policy concerns distinct to nursing homes necessitate the *Park Manor* regime as the rare exception to this generally applicable standard, it will need to decide whether these concerns require finding a CNA unit inappropriate despite CNAs' overwhelming community of interest. As the following section explains, CNAs' compelling community of interest trumps any countervailing policy concerns raised in *Park Manor*.

B. ***Park Manor*** **Cannot Be Understood Apart from the Legal and Factual Backdrop of the Supposed "Policy Against Unit Proliferation" in Acute Care Hospitals.**

In *Park Manor Care Center*, 305 NLRB 872 (1991), the Board introduced the "pragmatic or empirical" community-of-interests test for determining appropriate bargaining units in nursing homes in an effort to give some unspecified degree of effect to the anti-proliferation concerns that motivated the Board in its hospital unit rulemaking. In applying *Park Manor*, the Board has weighed generally applicable community-of-interest considerations against the unit limitation policy of the acute care rules. However, the Board has not made clear the appropriate weight this "anti-proliferation" factor should be given in determining appropriate bargaining units in nonacute health care facilities. We respectfully submit that in light of the history of the hospital bargaining unit rule where this factor originated, the explicit exclusion of nursing homes from that rule, and the dramatic differences in the function, organization and staffing between

hospitals and nursing homes, the Board should give this factor little, if any, weight outside of acute care hospitals.

Because of CNAs' strong community of interest, deciding this case under *Park Manor* necessarily turns on: (1) whether any consideration of anti-proliferation policies should be incorporated into the nursing home unit analysis; and (2) if so, what weight should these policies be given relative to community-of-interest considerations. Resolving these issues requires an understanding of the context in which *Park Manor* was decided. In particular, it is worth emphasizing a number of indisputable background considerations that must play a role in the Board's analysis:

- Congressional concern with undue unit proliferation stemmed directly from the inclusion in 1974 of not-for-profit hospitals within the Board's jurisdiction, which had always extended to nursing homes;
- Nursing home operations are substantially dissimilar to the acute care hospital operations that generated congressional concern;
- The Board expressly excluded nursing homes from the ambit of the hospital rules, which it promulgated only in the face of incompatible appellate review standards premised on the mistaken belief that a congressional admonition in the legislative history of the 1974 hospital amendments compelled some particular legal outcome;
- In upholding the hospital rules, the Supreme Court reaffirmed the Board's broad discretion to determine appropriate units even in acute care hospitals; and
- A fortiori, the Board is not statutorily obligated to give any particular weight to nonproliferation policies in nursing homes where there are far fewer occupational

and professional specialties performing a much narrower range of health care services.

1. Congressional Concern with Unit Proliferation in the Healthcare Industry was Directly Tied to the Addition of Nonprofit Hospitals to the Board's Jurisdiction, which had Always Included Nursing Homes.

Congressional concern with the risks of unit proliferation in the healthcare industry stemmed directly from the 1974 hospital amendments. These amendments brought nonprofit acute care hospitals within the Board's jurisdiction, *see* NLRA § 2(2), 29 U.S.C. § 152(2) (2006), which already included nursing homes. *See Drexel Home, Inc.*, 182 NLRB 1045, 1047 (1967) (asserting jurisdiction over a nonprofit nursing home). Some members of Congress feared that permitting the Board to apply its traditional community-of-interest standard in the complex and highly specialized acute care hospital industry would lead to "a multiplicity of bargaining units due to the diversified nature of the medical services provided patients." *See* Sen. Subcomm. On Labor, Comm. on Labor & Public Welfare, 93d Cong., 2d Sess., Legislative History of the Coverage of Non-Profit Hospitals Under the National Labor Relations Act at 113–14 (statement of Sen. Taft). These members feared that a large number of units in hospitals might lead to work stoppages that would adversely affect the public through service disruptions and higher medical costs. *See Amer. Hosp. Ass'n v. NLRB*, 499 U.S. 606, 615 (1991) (surveying the legislative history of the failed 1973 predecessor to the 1974 amendments).

Prior to the hospital amendments, the Board had treated nursing home unit determinations under its community-of-interest standard. *See, e.g.*, *Madeira Nursing Center, Inc.*, 203 NLRB 323, 325 (1973) (finding that LPNs "enjoy a substantial community of interest among themselves"). There is nothing in the congressional statements of concern regarding undue unit proliferation that suggests Congress was concerned with the Board's existing nursing

home unit determinations in addition to the potential for unit proliferation in acute care hospitals.[9]

In the intervening years between the 1974 hospital amendments and the Board's hospital unit rulemaking in 1988, proliferation concerns arose only in the acute care setting. As the Board noted in the rulemaking proceedings, it had not published a single case deciding appropriate nursing home units between the 1974 amendments and the rulemaking. *See* Second Notice of Proposed Rulemaking, 53 Fed. Reg. at 33,928.

When the Board decided that rulemaking was needed to address the proliferation concerns in acute care hospitals and the conflicting appellate court decisions that this concern had generated, it expressly excluded nursing homes from the coverage of those rules. *See* Rules and Regulations of the NLRB § 103.30(g) ("The Board will determine appropriate units in [] health care facilities [other than acute care hospitals] . . . by adjudication."). In so doing, the Board implicitly recognized that nursing homes present far less opportunity for proliferation than acute care hospitals. Indeed, the Board took note of the fact that nursing homes tend to employ few professionals and that nursing home staff tend to be more functionally integrated. *See* Second Notice of Proposed Rulemaking, 53 Fed. Reg. at 33,928. Thus, the Board concluded that the hospital rules and their anti-proliferation policy were unnecessary in the nursing home setting.[10] *Id.* at 33,929.

[9] In its admonition against unit proliferation, Congress did register its approval of three Board decision including a single nursing home case. *See* S. Rep. No. 93-766, p. 5 (1974) and H. R. Rep. No. 93-1051, pp. 6-7 (1974)). In that case, the Board relied "especially [on] the fact that the maintenance employees primarily perform duties not requiring a high degree of skill of specialized training" to reject a two-person maintenance unit as insufficiently distinct from housekeeping and other employees. *Four Seasons Nursing Center*, 208 NLRB 403, 403 (1974). It is unclear whether congressional approval was motivated by the Board's disapproval of a two-person unit, its rejection of a separate maintenance unit, or both. What is certain is that neither of these rationales has any bearing on the appropriateness of a CNA unit defined in significant part by its skill set, specialized training, and size relative to other nursing home job classifications.

[10] The Board also relied on its finding that staffing patterns and employee qualifications varied widely from state to state and among skilled, intermediate, and residential care facilities. *See* Second Notice of Proposed Rulemaking, 53

The Board's implicit recognition—that nursing homes, unlike hospitals, do not present unit proliferation concerns—was well-founded. Nursing homes, unlike hospitals, generally have no physicians or specialized departments and few technicians, LPNs, and RNs on staff, most of whom serve in a supervisory capacity over the CNAs. *See* Part I, *supra*. Nursing homes also tend to have few skilled maintenance or business office clerical employees. *See, e.g.*, *Charter Hosp. of St. Louis*, 313 NLRB 951 (1994) (four business office clerical employees in a 60-bed psychiatric hospital). In light of this diminished potential for adverse consequences to the public due to unit proliferation—such that application of the traditional standard would not result in significantly greater proliferation problems than in any other industry—the hospital rules' limitations on the number and composition of appropriate units unnecessarily restrict employee free choice and collective bargaining in nursing homes. *See Fair Oaks Anesthesia Assocs. v. NLRB*, 975 F.2d 1068, 1073 (4th Cir. 1992) ("[I]t would border on the senseless to hold an employer with only two categories of employees to a rule developed for a large acute care institution like the Hospital."); *NLRB v. Hillview Health Care Center*, 705 F.2d 1461, 1470 (7th Cir. 1983) (noting that an LPN unit did not raise undue proliferation concerns because the nursing home employed no other technical employees, no physicians, and only two RNs, both of whom were supervisors).

2. The Board Crafted the Hospital Rules in Response to Conflicting Bodies of Appellate Court Decisions, all of which were Ultimately Incorrect.

In addition to being promulgated in response to the Board's perception of the congressional concern with respect to the potential consequences of unit proliferation in highly specialized acute care facilities, the hospital rules are also a product of the hostile legal

---

Fed. Reg. at 33,927–28. These variations were largely eliminated by the 1987 federal regulations, which had the effect of standardizing both state regulations generally and qualifications for CNAs and other nursing personnel in particular. *See supra* Part I.A.

environment in which they were promulgated. Repeated Board efforts to accommodate congressional concerns regarding unit proliferation in acute care hospitals were met with reversals in the appellate courts. The circuits fundamentally disagreed over how to understand the legal significance of a congressional admonition expressed only in legislative history and not linked to any statutory text.

More than half of the circuit courts had held that this admonition required the Board to balance community-of-interest criteria against the public interest in undue proliferation, but had declined to specify the weight to be accorded to each consideration. *See IBEW, Local Union No. 474 v. NLRB*, 814 F.2d 697, 704 (D.C. Cir. 1987) (collecting cases from the 2d, 3d, 4th, 6th, 7th, and 11th circuits). Two other circuits had required the Board to effectuate a policy of nonproliferation by employing the so-called "disparity-of-interest" analysis instead of the traditional community-of-interest approach, *see Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981); *NLRB v. St. Francis Hosp.*, 601 F.2d 404, 419 (9th Cir. 1979). The D.C. Circuit subsequently rejected the "disparity" analysis as having "no basis in the law." *IBEW, Local Union No. 474*, 814 F.2d at 715. This left the Board in the untenable situation of being unable to establish hospital units in any areas covered by the Ninth or Tenth Circuits—or any other courts that might adopt the disparity-of-interest test—because parties could successfully challenge those units in the D.C. Circuit.

These constraints left the Board little choice but to engage in its unprecedented rulemaking efforts in order to give adequate consideration to both the proliferation concerns highlighted by the appellate courts and the traditional community-of-interest principles that form the foundation of the Board's appropriate unit analysis. Consequently the rules reflect the Board's attempt to craft rules that would survive appellate review as much as its substantive

policy judgments. In promulgating the hospital rules, the Board charted a middle course between the Ninth and D.C. Circuit positions by validating certain units it had consistently approved under a community-of-interest analysis while rejecting most other less-established units in order to comply with the circuit decisions mandating nonproliferation. *See* Notice of Proposed Rulemaking, 52 Fed. Reg. 25,142, 25,143 (July 2, 1987) ("[T]he key element in the Board's avoidance of proliferation is to designate how many units will be deemed appropriate in a particular type of health care facility. In so doing, the Board must effectuate section 7 rights by permitting bargaining in cohesive units . . . .").

3. The Supreme Court Made Clear in *American Hospital Association* that the Board Retains Broad Discretion to Determine Appropriate Units in All Industries.

The above sections show that the hospital rules are a peculiar product of the unique factual and legal problems they were designed to address. In upholding the validity of the hospital rules, however, the Supreme Court held that the congressional admonition against proliferation carried no legal import for the Board's broad discretion to determine appropriate bargaining units.

The NLRA grants the Board broad discretion to determine appropriate bargaining units that will "assure to employees the fullest freedom in exercising their rights" under the Act. *See* NLRA § 9(b). Because "determining what constitutes an appropriate unit 'involves of necessity a large measure of informed discretion,'" the Board's conclusions are "rarely to be disturbed." *See Country Ford Trucks, Inc. v. NLRB*, 229 F.3d 1184, 1189 (D.C. Cir. 2000) (quoting *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947)). For this reason, a court of appeals will not overturn a Board's bargaining unit determination "unless it is arbitrary or not supported by substantial evidence in the record." *Id.*

The Board's well-established discretion is no less valid in the healthcare industry. In upholding the hospital rules, the Supreme Court made clear that the Board was not legally compelled to promulgate rules to avoid undue unit proliferation in the health care industry. *See Amer. Hosp. Ass'n v. NLRB*, 499 U.S. 606, 616 (1991). The Court explained that due to the absence of relevant statutory text in the hospital amendments, the legislative history should be read as merely "an expression by the Committees of their desire that the Board give 'due consideration' to the special problems that 'proliferation' might create in acute care hospitals." *Id.*

The Court concluded that to the extent the Board believed it sound policy to limit unit proliferation in acute care hospitals, it remained free to craft any rules justified by its expertise and experience. *See id.* at 618 (noting the Board's "careful analysis" and "well-reasoned justification" for the hospital rules). As a corollary, the Board remained equally free to craft exceptions to those rules as needed to effectuate the policies behind them. *See id.* at 619 (approving the "extraordinary circumstances" exception contained in section 103.30(a)–(b) of the hospital rules). Thus the Board has no statutory obligation to apply the hospital rules in the nursing homes excluded from the rules upheld by the Court, much less to apply them in a rigid or mechanical fashion as the Employer here asserts.

C. Even Under *Park Manor*, A CNA-Only Unit Should Be Deemed Appropriate.

The Board should decline the employer's invitation to extend the hospital rules to appropriate unit determinations in nursing homes. The hospital rules are inapposite to resolving the nursing home CNA unit question for two significant reasons. *First*, the imperative in the rulemaking to limit the total number of appropriate units, combined with compelling evidence put forth for preserving separate units for physicians, RNs, technical, and skilled maintenance,

left little opportunity for the Board to consider differences among nonprofessional hospital employees that might justify granting them separate representation. *See* Second Notice of Proposed Rulemaking, 53 Fed. Reg. at 33,927 (devoting only a single paragraph of its nearly 80-page record to nonprofessionals). *Second*, and more important, is the fact that even assuming the Board's minimal treatment of hospital nonprofessionals was adequate, there are no individual nonprofessional hospital occupations that possess a community of interest equivalent to that demonstrated by nursing home CNAs.

Although the hospital rules are of limited usefulness in assessing the appropriateness of a nursing home CNA unit, the reasoning underlying the rules may serve as a useful guide to the extent the Board believes there is a public policy interest in giving some weight to proliferation concerns in nursing homes. In promulgating the hospital rules, the Board relied heavily on traditional community-of-interest factors. *See Park Manor*, 305 NLRB at 875 (noting that the factors it examined in the rulemaking were similar to those used in community-of-interest cases). In so doing, the Board found that certain units—for example the hospital RN unit—demonstrated a community of interest sufficiently compelling to outweigh countervailing unit proliferation concerns. The following section applies this approach to nursing home CNAs and concludes that, like RNs in acute care hospitals, CNAs employed in nursing homes constitute an appropriate bargaining unit.

1. Application of *Park Manor* Should Consider CNAs' Strong Community of Interest.

The Board's starting point under *Park Manor* should be to examine a proposed unit's community of interest instead of rejecting it simply because the hospital rules reached a different result in a distinctly different context. Taking this approach, a nursing home CNA unit is

appropriate, despite the Board's nonproliferation policy, for reasons similar to those supporting the Board's conclusion that a hospital RN unit is appropriate under the Act.

In Second Notice of Proposed Rulemaking, the Board found that RNs:

(a) Work around the clock, 7 days a week;
(b) Have constant responsibility for direct patient care;
(c) Are subject to common supervision by other nurses;
(d) Share similar education, training, experience and licensing not shared by other employees;
(e) Have the most contact with other RNs; and
(f) Have a lengthy history of separate organization and bargaining.

Second Notice of Proposed Rulemaking, 53 Fed. Reg. at 33,911. In elaborating on these factors, the Board found significant that RNs were the only hospital professionals who were required as a group to be on duty 24 hours a day, seven days a week. *Id.* These factors resulted in nurses being much more concerned than other professionals with issues such as alternative scheduling and premium pay for evening, overnight, and weekend shifts. *Id.* at 33,915. The Board took notice of nurses' continuous interaction with patients and the fact that RNs have primary responsibility for monitoring patients' overall care, including spotting errors made by other professionals. *Id.* at 33,911. It also pointed to a study concluding that "perception of nursing care is the single most crucial aspect in the overall rating of hospitals by patients." *Id.*

The Board found that nurses, unlike other professionals, are supervised by the director of nursing. *Id.* Because of the special skills and licensure required of nurses, they comprise a labor market distinct from other professionals. *Id.* at 33,912. For this reason, the Board found that "[t]here is no pressure from outside the hospital industry forcing up wages, as for example is the case with pharmacists." *Id.* The Board also observed that "RN career ladders are very short in terms of pay, quickly leveling out after relatively brief experience." *Id.*

Regarding education and training, the Board found that RNs and not other professionals needed to pass a national uniform licensing exam and follow state nurse practice acts and that for this reason, "no other health care worker may function as a nurse under [state] nurse practice acts." *Id.* This prohibition also placed a practical limit on interchange between nurses and non-nursing professionals. *Id.* In addition, interchange between these groups was limited due to "non-nurse professionals generally [being] located away from patient units" and the differing scheduling demands discussed above. *Id.*

The Board analyzed the potential impact of separate RN units for collective bargaining. It noted that because RNs constituted approximately 23% of the hospital workforce and would generally constitute 80% or more of a broad professional unit, there was legitimate concern that the large numbers and distinct concerns of RNs would overwhelm concerns raised by non-RNs included in such a unit. *Id.* at 33,914.

In addition to the drawbacks for non-nurses, the Board also noted the potential benefits for both RNs and patients of permitting a separate RN unit. The Board recognized the "unprecedented and severe nursing shortage" at the time of the rulemaking and noted that "[w]hile separate representation for the RNs does not provide the complete solution to this problem, we believe that it is an important step toward making the nursing profession a more attractive employment opportunity . . . ." *Id.* at 33,916. To this end, the Board took note of testimony by nurses "that they view collective bargaining, in their own unit, as the vehicle for improvement in their working conditions and for allowing them a voice in patient care." *Id.*

Finally, the Board found that "the evidence in the record does not support the assumption that the recognition of RN-only units will lead to a demand by other professional groups to organize as separate units." *Id.* It rejected this concern as "speculative [] and insufficient reason

to deny RNs who have already established their unique concerns and a highly separate identity, a separate bargaining unit." *Id.*

Nursing home CNAs clearly share with hospital RNs nearly all the traits that justified the latter group's separate unit status.[11] Like hospital RNs, CNAs are the primary caregivers in nursing homes. Unlike their other nonprofessional colleagues, CNAs as a group provide round-the-clock coverage and spend nearly all their working hours engaged in direct patient care. They are supervised by the director of nursing instead of other administrative personnel. Like hospital RNs, CNAs in nursing homes have specific certification and training requirements that foreclose interchange with other employees. Their unique qualifications also create a labor market distinct from dietary, housekeeping and maintenance workers, who can perform these jobs across a wide variety of industries. In addition, there is potential for nursing home CNAs' unique concerns—such as high turnover and workforce shortages resulting in occupational injuries and wage and hour violations—to overwhelm those of their nonprofessional colleagues, just as similar concerns from RNs threatened to do for other hospital professionals. Finally, there is no evidence that recognizing CNAs as a separate unit will lead to undue unit proliferation in nursing homes, both due to the infrequency of the professional and technical units generally found in hospitals and the fact that most other nursing home job classifications are unlikely to evince the same level of distinctiveness demonstrated by CNAs.

[11] To the extent that there is little separate bargaining history for most nursing home CNAs, this fact is best explained by external circumstances, not a lack of distinct identity or desire for separate representation. Prior to the federal regulations in 1987, nursing home aides and orderlies were not subject to the training and certification requirements that contribute to their distinct labor market and unique status among nursing home personnel. After that Act was implemented, the Board's hospital rulemaking cast a long shadow that discouraged unions from seeking stand-alone CNA units.

2. The Board Should Not Only Find the CNA Unit Appropriate in the Instant Case, but Should Also Recognize Nursing Home CNA Units as Typically Appropriate in Future Cases.

In *Park Manor*, the Board stated that it expected over time to identify "recurring factual patterns" that would indicate "which units are typically appropriate." 305 NLRB at 875 (quoting *St. Francis Hosp.*, 271 NLRB 948, 953 n.39 (1984)). Designating units as "typically appropriate" under *Park Manor*—like treating certain units in other industries as presumptively appropriate—reduces litigation over unit scope that often delays elections and hinders employee free choice. *See, e.g.*, *AVI Foodsystems, Inc.*, 328 NLRB 426, 426 (1999) (holding that the single-facility unit of cafeteria workers was "presumptively appropriate" and that the employer failed to meet its burden of introducing "relevant affirmative evidence" to rebut that presumption (citing *J&L Plate, Inc.*, 310 NLRB 429, 429 (1993))).

The factors that make the CNA unit so clearly appropriate in the instant case are also present in nearly every other nursing facility due to the federal regulatory regime that carves out a unique role for CNAs among long term care providers. As the Board is already aware, the "long-term care industry . . . has undergone a radical transformation in the past 20 years." *Specialty Healthcare*, 356 NLRB at slip op. 2. Unlike the state of "rapid transition" that existed when *Park Manor* was decided, *see id.*, nursing home occupational structures have now become largely standardized due to the uniform federal regulatory regime. Consequently, the Board need not delay elections for meritless objections or repetitive fact-finding by revisiting the appropriateness of a CNA unit in each future case. *See Allen Health Care Services*, 332 NLRB 1308, 1308 (2000) (holding that because the union had petitioned for a unit not considered presumptively appropriate, the Board's duty to determine an appropriate unit in each case

required remand for development of the record even though the employer had not objected to the unit sought).

Instead, the Board should rely on the uniformity of nursing home operations in designating CNA units as typically appropriate. Where the Board has recognized a unit as typically or presumptively appropriate, an objecting employer bears the burden of showing that the unit is "truly inappropriate" in that particular case. *See Blue Man Vegas*, 529 F.3d at 421 ("[T]he employer's burden is to show the *prima facie* appropriate unit is 'truly inappropriate.'" (quoting *Country Ford Trucks*, 229 F.3d at 1189)). To meet this burden, an employer must demonstrate that "the excluded employees share an overwhelming community of interest with the included employees" such that "there is no legitimate basis upon which to exclude them." *Id.* (citing *Trident Seafoods, Inc. v. NLRB*, 101 F.3d 111, 120 (D.C. Cir. 1996). This burden is virtually impossible to meet absent a showing that a unit is "irrational" or "unsupported by substantial evidence." *Id.* Therefore the Board should approve CNA units unless the employer can demonstrate that CNAs in a particular facility lack all of the distinct community-of-interest factors they typically exhibit.

The status of the remaining nonprofessional employees in nursing homes does not present an obstacle to designating CNA units as typically appropriate. The Board's concern with "leftover" units under *Park Manor*, *see* 305 NLRB at 875 n.18, is solely the product of the anti-proliferation principle from the hospital rules, which prompted the Board to employ rulemaking to establish a ceiling on the total number of appropriate units and then fit every occupational classification into the resulting framework. This approach is impracticable, if not impossible,

through adjudication.[12] Nor is it necessary: because it is fundamental that the Board need only find *an* appropriate unit, not the *most* appropriate unit, mere speculation that the remaining nonprofessional employees may lack a community of interest distinct from CNAs does not constitute grounds for rejecting the CNA unit.[13]

CONCLUSION

Nursing home CNAs provide a unique set of services and share a distinct set of concerns regarding staffing, scheduling, training, and other conditions of employment. In short, CNAs not only share a community of interest, but share one that is both significantly distinct from their nursing home colleagues and strikingly similar to that shared by hospital RNs. For these reasons, the Board should conclude that a CNA unit is typically or presumptively appropriate regardless of whether it reaches that result under *Park Manor* or the traditional community-of-interest analysis.

[12] Proceeding via adjudication is almost certainly necessary given the wide variety of nonacute care facilities to which *Park Manor* now applies. *See The Developing Labor Law* Ch. 11.IIIC.1.f. (5th ed., John E. Higgins, Jr., ed., 2006).

[13] This issue is properly dealt with under the Board's residual unit doctrine. *See Kaiser Found. Health Plan of Colo*., 333 NLRB 557, 558 (2001) (holding that unrepresented employees in a nonacute care facility who share interests with an existing unit can vote for separate representation or for joining the existing unit). This doctrine applies only to whether the residual unit is appropriate and has no bearing on whether the initial unit is appropriate. *See Blue Man Vegas*, 529 F.3d at 427.

Respectfully submitted,

Judith A. Scott, General Counsel
John J. Sullivan, Associate General Counsel
Ryan E. Griffin, Law Fellow
Service Employees International Union
1800 Massachusetts Avenue, NW
Washington, DC 20036
(202) 730-7327

By: _____/s/_____
Judith A. Scott

March 8, 2011

CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of March, 2011, the foregoing document Brief of Amicus Curiae Service Employees International Union was sent via email or facsimile to the following:

Anthony Mays, Executive Director
Kindred Healthcare of Mobile
1758 Spring Hill Avenue
Mobile, AL 36607

Edward J. Goddard, Esq.
Kindred Healthcare, Inc.
680 South Fourth Street
Louisville, KY 40202

Clifford H. Nelson Jr., Esq.
Leigh E. Tyson, Esq.
Constangy, Brooks & Smith LLC
230 Peachtree Street NW, Suite 2400
Atlanta, GA 30303

Charles P. Roberts, Esq.
Constangy, Brooks & Smith LLC
100 North Cherry Street, Suite 300
Winston-Salem, NC 27101

Randy Rigsby, Staff Organizer
United Steelworkers, District 9
919 Sharit Avenue, Suite 213
Gardendale, AL 25071

Daniel M. Kovalik, Assistant General Counsel
United Steelworkers
5 Gateway Center
Pittsburgh, PA 15222

Richard P. Rouco, Esq.
Whatley Drake LLC
2001 Park Place North
Birmingham, AL 35203

Kathleen McKinney, Regional Director
NLRB Region 15
600 South Maestri Place, 7th Floor
New Orleans, LA 70130-3413

/s/
Ryan E. Griffin